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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
09/812,704	03/19/2001	Charles Lewis	01-P-24995	9722

7590 05/06/2004

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EXAMINER	
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ART UNIT	**PAPER NUMBER**
3626	

DATE MAILED: 05/06/2004

Please find below and/or attached an Office communication concerning this application or proceeding.

KS

Office Action Summary	Application No. 09/812,704	Applicant(s) LEWIS ET AL.	
	Examiner Luke Gilligan	Art Unit 3626	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If the period for reply specified above is less than thirty (30) days, a reply within the statutory minimum of thirty (30) days will be considered timely.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on 2/9/04.

2a)☐ This action is **FINAL**. 2b)☒ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) 1-56 is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) 1-56 is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).

11)☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. § 119

12)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____.

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

Attachment(s)

1) ☒ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☐ Information Disclosure Statement(s) (PTO-1449 or PTO/SB/08) Paper No(s)/Mail Date _____.
4) ☐ Interview Summary (PTO-413) Paper No(s)/Mail Date. _____ .
5) ☐ Notice of Informal Patent Application (PTO-152)
6) ☐ Other: _____.

R spons to Am ndment

1. In the amendment filed 2/9/04 in paper number 20, the following has occurred: claims 1-8, 10, 12-13, 19, 25, -26, 30-32, 35, 37, 41, 46, 47, 53, and 55 have been amended. No claims have been added or canceled.

2. Now, claims 1-56 are presented for examination.

Claim Rejections - 35 USC § 102

3. The following is a quotation of the appropriate paragraphs of 35 U.S.C. 102 that form the basis for the rejections under this section made in this Office action:

> A person shall be entitled to a patent unless –
>
> (b) the invention was patented or described in a printed publication in this or a foreign country or in public use or on sale in this country, more than one year prior to the date of application for patent in the United States.

4. Claims are rejected under 35 U.S.C. 102(b) as being anticipated by Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman).

5. As per claim 37, Freeman teaches a healthcare management optimization system for a healthcare practice including a plurality of physicians participating in an insurance network comprising: a first database comprising medical procedures other than those performed directly by one of the plurality of physicians to thereby define ancillary medical procedures that are preferred by the insurance network (see column 2, lines 54-64 and column 6, lines 35-41; additionally, see response to argument 1 below); a second database comprising medical costs other than those attributed directly to medical procedures performed by one of the plurality of physicians to thereby define ancillary medical costs of each of the plurality of physicians participating in the insurance network (see column 2, lines 54-64 and column 6, lines 35-41); an analyzer in communication with the first and second databases for analyzing the data in the first and second databases and comparing the ancillary medical procedures that are preferred by

the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network to thereby identify ancillary medical costs of the physicians that are not preferred by the insurance network (see column 9, line 16 – column 10, line 5); and managing means responsive to the analyzer for managing the ancillary medical costs identified as not being preferred by the insurance network of the healthcare practice to thereby modify the ancillary medical costs of the physicians in the healthcare practice to be more profitable to the insurance network (see column 9, line 16 – column 10, line 5).

6. As per claim 46, Freeman teaches a healthcare management optimization system for a healthcare practice including a plurality of physicians participating in an insurance network comprising: a server having at least one database (see figures 1 and 2); a communications network positioned to be in communication with the server (see figures 1 and 2); a plurality of computers positioned to be in communication with the communications network, each including a user interface responsive to a user (see figures 1and 2); an updater positioned on the server and responsive to the user interface updating each of the plurality of physicians in the healthcare practice of any changes in the management of medical costs other than those attributed directly to a medical procedure performed directly by one of the plurality of physicians to thereby define ancillary medical costs that are preferred by the insurance network (see column 6, lines 1-14; also see response to argument 1 below); and recommending means positioned on the server and responsive to the user interface for recommending to each of the plurality of physicians alternative medical procedures other than those performed directly by one of the plurality of physicians to thereby define ancillary medical procedures that are preferred by the insurance network (see column 9, lines 16-21).

7. As per claim 47, Freeman teaches the system of claim 47 as described above, wherein the at least one database comprises a first and second database, the first database including ancillary medical procedures that are more preferred by the insurance network and wherein the second database includes ancillary medical costs of each of the plurality of physicians participating in the insurance network (see column 9, line 16 – column 10, line 5).

8. As per claim 48, Freeman teaches the system of claim 47 as described above, further comprising an analyzer in communication with the first and second databases for analyzing the data in the first and second databases and comparing the ancillary medical procedures that are preferred by the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network to thereby identify ancillary medical costs of the physicians that are not preferred by the insurance network (see column 9, line 16 – column 10, line 5).

9. As per claim 49, Freeman teaches the system of claim 48 as described above, further comprising managing means responsive to the analyzer for managing the ancillary medical costs of the healthcare practice identified as not being preferred by the insurance network to thereby modify the ancillary medical costs of the physicians in the healthcare practice to be more profitable to the insurance network (see column 9, line 16 – column 10, line 5).

Claim Rejections - 35 USC § 103

10. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

> (a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.

11. Claims are rejected under 35 U.S.C. 103(a) as being unpatentable over Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman) in view of Segal and Wang, **Influencing Physician Prescribing** (hereinafter Segal).

12. As per claim 1, Freeman teaches a method of managing a healthcare practice participating in an insurance network to enhance profitability of the healthcare practice with respect to a predetermined reimbursement amount for pharmacy costs, the method comprising: gathering data from each of a plurality of physicians in the healthcare practice participating in the insurance network regarding management of the pharmacy costs other than those attributed by a medical procedure performed directly by one of the plurality of physicians when the physician directly administers a medication to a patient to thereby define ancillary pharmacy costs (see column 3, lines 10-15 and response to argument 1 below); identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network that prescribes medications that don't follow requirements of the insurance network (see column 9, lines 17-21 and column 10, lines 2-5). Freeman does not explicitly teach identifying physicians at a greater risk of not receiving the predetermined reimbursement amount for the pharmacy costs from the insurance network and modifying the physicians management behavior to reduce the risk of not receiving the reimbursement amount. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for pharmacy costs from an insurance network by prescribing medications that are detrimental to receiving the predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying physician's management behavior regarding the pharmacy costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the pharmacy costs from the insurance network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of

healthcare management at the time of the invention to incorporate the steps of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

13. As per claim 2, Freeman in view of Segal teach the method of claim 1 as described above. Freeman further teaches gathering information regarding the ancillary pharmacy costs of each of the plurality of physicians in the healthcare practice participating in the insurance network from a database associated wit ha pharmacy network, the database positioned on a server in communication with each of a plurality of pharmacies in the pharmacy network participating in the insurance network (see column 6, lines 35-41).

14. As per claim 5, Freeman in view of Segal teach the method of claim 1 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative prescription medication. Segal discloses modifying physicians management behavior regarding the pharmacy costs comprises educating the at least one physician on the benefits of alternative prescription medications using research literature for comparing the alternative medications to the prescribed medications and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative prescription medications (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

15. As per claim 6, Freeman in view of Segal teach the method of claim 5 as described above. Freeman does not explicitly teach modifying a physician's management behavior by

preparing a list of prescription medications for the physician. Segal discloses the step of modifying at least on physician's management behavior further comprising preparing a list of prescription medications that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

16. As per claim 7, Freeman in view of Segal teach the method of claim 6 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom prescription medication forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom prescription medications forms that include prescription medications that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

17. As per claim 8, Freeman in view of Segal teach the method of claim 7 as described above. Freeman does not explicitly teach modifying the at least one physician's management behavior by preparing a list of common prescription medications that are approve by a plurality of insurance networks. Segal teaches modifying the at least one physician's management behavior by preparing a list of common prescription medications that are approve by a plurality of insurance networks (see paragraph 61). It would have been obvious to one of ordinary skill in

the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

18. As per claim 9, Freeman in view of Segal teach the method of claim 7 as described above. Freeman further teaches analyzing a patient's prescription history to thereby avoid possible adverse prescription medication reactions (see column 8, lines 54-67).

19. As per claim 10, Freeman in view of Segal teach the method of claim 9 as described above. Freeman does not explicitly teach identifying at least one patient whose present prescription medications put the at least one physician at risk for not receiving the predetermined reimbursement and amending and discontinuing the at least one patient's prescription medications that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present prescription medications put the at least one physician at risk for not receiving the predetermined reimbursement and amending and discontinuing the at least one patient's prescription medications that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

20. As per claim 11, Freeman in view of Segal teach the method of claim 10 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present prescription medication is discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

21. As per claim 12, Freeman in view of Segal teach the method of claim 1 as described above. Freeman further teaches updating each of the plurality of physicians in the healthcare

practice of any changes in the management of pharmacy costs from the insurance network (see column 5, lines 58 – column 6, line 7).

22. Claims 13, 14, and 17-23 contain substantially similar limitations for managing ancillary medical costs as claims 1, and 5-12 and, as such, are rejected for similar reasons as given above.

23. As per claim 24, Freeman in view of Segal teach the method of claim 20 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

24. As per claim 25, Freeman teaches a method of optimizing the profitability of an insurance network having a plurality of physicians in a healthcare practice participating therein by managing ancillary medical costs, the method comprising the steps of: gathering data from each of a plurality of physicians in the healthcare practice participating in the insurance network regarding management of medical costs other than those attributed directly to procedures performed by one of the plurality of physicians to thereby define ancillary medical costs (see column 3, lines 10-15); identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network that doesn't follow requirements of the insurance network in terms of medical costs (see column 9, lines 17-21 and column 10, lines 2-5); modifying the plurality of physicians' in the healthcare practice management behavior regarding ancillary medical costs that are not profitable for the insurance network (see column 9, lines 16-19, in particular, "insuring that the entities meet the requirements set by the cooperative"); and providing a financial incentive to the insurance network and the plurality of physicians in the healthcare practice participating in the insurance network to modify the plurality of physicians; management behavior of ancillary medical costs that are not as profitable to the insurance network (see column 7, lines 38-52).

25. Freeman does not explicitly teach identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network that is at a greater risk of not receiving a predetermined reimbursement amount for the ancillary medical costs from the insurance network by performing activities that are detrimental to receiving the predetermined reimbursement amount for the ancillary medical costs. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for pharmacy costs from an insurance network by prescribing medications that are detrimental to receiving the predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying those physician's management behavior regarding the pharmacy costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the pharmacy costs from the insurance network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the steps of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

26. As per claim 26, Freeman in view of Segal teach the method of claim 25 as described above. Freeman further teaches the step of gathering data includes gathering information regarding the ancillary medical costs of each of the plurality of physicians participating in the insurance network from databases associated with the insurance networks, the databases positioned on servers in communication with each of a plurality of ancillary medical facilities participating in the insurance networks (see column 6, lines 35-41).

27. As per claims 27, Freeman in view of Segal teach the method of claim 26 as described above. Freeman further teaches identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network whose management of ancillary medical costs is not profitable to the insurance network (see column 10, lines 2-5, in particular, "monitor the comparative effectiveness of health care providers, both in terms of patient outcomes and cost").

28. As per claim 35, Freeman in view of Segal teach the method of claim 25 as described above. Freeman further teaches updating each of the plurality of physicians in the healthcare practice of new ancillary medical procedures that are more profitable to the insurance network (see column 5, line 58 – column 6, line 7).

29. As per claim 36, Freeman in view of Segal teach the method of claim 35 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

30. As per claim 38, Freeman teaches the system of claim 37 as described above. Freeman does not explicitly teach identifying physicians at a greater risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network and modifying the physicians management behavior to reduce the risk of not receiving the reimbursement amount. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for ancillary medical costs from an insurance net work by performing ancillary medical procedures that are detrimental to receiving the predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying physician's management behavior regarding the ancillary medical costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance

network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the feature of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

31. As per claim 50, Freeman teaches the system of claim 49 as described above. Freeman does not explicitly teach identifying physicians at a greater risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network and modifying the physicians management behavior to reduce the risk of not receiving the reimbursement amount. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for ancillary medical costs from an insurance net work by performing ancillary medical procedures that are detrimental to receiving the predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying physician's management behavior regarding the ancillary medical costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the feature of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

32. Claims are rejected under 35 U.S.C. 103(a) as being unpatentable over Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman) in view of Segal and Wang, **Influencing Physician Prescribing** (hereinafter Segal) and further in view of Glass, Pieper, and Berlin, **Incentive-Based Physician Compensation Models** (hereinafter Glass).

33. As per claim 3, Freeman in view of Segal teach the method of claim 2 as described above. Freeman does not explicitly teach calculating an average pharmacy cost per physician and determining which physicians are a predetermined percentage greater that the average pharmacy cost. Glass discloses a model for calculating an average pharmacy cost per physician for healthcare practices, and identifying the physicians that have pharmacy costs that are a predetermined percentage greater than the average pharmacy costs per physician for the healthcare practice (see paragraphs 45-51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this step into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

34. As per claim 4, Freeman in view of Segal and Glass teach the method of claim 3 as described above. Freeman does not explicitly teach identifying at least one physician having the highest pharmacy costs within the healthcare practice. Glass teaches teach identifying at least one physician having the highest pharmacy costs within the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management to combine this with the method of Freeman for the reasons give above with respect to claim 3.

35. Claims 15 and 16 contain substantially similar limitations for managing ancillary medical costs as claims 3 and 4 and, as such, are rejected for similar reasons as given above.

36. As per claim 28, Freeman in view of Segal teach the method of claim 27 as described above. Freeman does not explicitly teach calculating an average ancillary medical cost per physician and determining which physicians are a predetermined percentage greater that the average ancillary medical cost. Glass discloses a model for calculating an average ancillary medical cost per physician for healthcare practices, and identifying the physicians that have ancillary medical costs that are a predetermined percentage greater than the average ancillary medical costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this step into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

37. As per claim 29, Freeman in view of Segal teach the method of claim 27 as described above. Freeman does not explicitly teach identifying at least one physician having the highest ancillary medical costs within the healthcare practice. Glass teaches teach identifying at least one physician having the highest ancillary medical costs within the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management to combine this with the method of Freeman for the reasons give above with respect to claim 3.

38. As per claim 30, Freeman in view of Glass teaches the method of claim 28 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative ancillary medical procedures. Segal discloses modifying physicians management behavior regarding the ancillary medical costs comprises educating the at least one physician on the benefits of alternative ancillary medical procedures using research literature for comparing the alternative ancillary medical procedures with current ancillary

medical procedures and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative ancillary medical procedures (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the steps of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

39. As per claim 31, Freeman in view of Glass and Segal teach the method of claim 30 as described above. Freeman does not explicitly teach modifying a physician's management behavior by preparing a list of ancillary medical procedures for the physician. Segal discloses the step of modifying at least on physician's management behavior further comprising preparing a list of ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 30.

40. As per claim 32, Freeman in view of Glass and Segal teach the method of claim 31 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom ancillary medical procedure forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom ancillary medical procedure forms that include ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the ancillary medical costs (see paragraph 61). It

would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 30.

41. As per claim 33, Freeman in view of Glass and Segal teach the method of claim 32 as described above. Freeman does not explicitly teach identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 30.

42. As per claim 34, Freeman in view of Glass and Segal teach the method of claim 33 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present ancillary medical procedures are discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

43. As per claim 39, Freeman in view of Segal teach the system of claim 38 as described above. Freeman does not explicitly teach calculating an average ancillary medical cost per physician and determining which physicians are a predetermined percentage greater that the average ancillary medical cost. Glass discloses a model for calculating an average ancillary

medical cost per physician for healthcare practices, and identifying the physicians that have ancillary medical costs that are a predetermined percentage greater than the average ancillary medical costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this feature into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

44. As per claim 40, Freeman in view of Segal and Glass teach the system of claim 39 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative ancillary medical procedures. Segal discloses modifying physicians management behavior regarding the ancillary medical costs comprises educating the at least one physician on the benefits of alternative ancillary medical procedures using research literature for comparing the alternative ancillary medical procedures with current ancillary medical procedures and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative ancillary medical procedures (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the features of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

45. As per claim 41, Freeman in view of Segal and Glass teach the system of claim 40 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom ancillary medical procedure forms for the physician. Segal

discloses the step of modifying at least one physician's management behavior further comprises providing custom ancillary medical procedure forms that include ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the ancillary medical costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 40.

46. As per claim 42, Freeman in view of Segal and Glass teach the system of claim 41 as described above. Freeman does not explicitly teach identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 40.

47. As per claim 43, Freeman in view of Glass and Segal teach the system of claim 42 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present ancillary medical procedures are discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

48. As per claim 44, Freeman in view of Glass and Segal teach the system of claim 42 as described above. Freeman further teaches updating each of the plurality of physicians in the healthcare practice of new ancillary medical procedures that are more profitable to the insurance network (see column 5, line 58 – column 6, line 7).

49. As per claim 45, Freeman in view of Glass and Segal teach the system of claim 44 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

50. As per claim 51, Freeman in view of Segal teach the system of claim 50 as described above. Freeman does not explicitly teach calculating an average ancillary medical cost per physician and determining which physicians are a predetermined percentage greater that the average ancillary medical cost. Glass discloses a model for calculating an average ancillary medical cost per physician for healthcare practices, and identifying the physicians that have ancillary medical costs that are a predetermined percentage greater than the average ancillary medical costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this feature into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

51. As per claim 52, Freeman in view of Glass and Segal teach the system of claim 51 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative ancillary medical procedures. Segal discloses modifying physicians management behavior regarding the ancillary medical costs comprises educating the at least one physician on the benefits of alternative ancillary medical procedures using research literature for comparing the alternative ancillary medical procedures

with current ancillary medical procedures and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative ancillary medical procedures (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the features of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

52. As per claim 53, Freeman in view of Glass and Segal teach the system of claim 52 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom ancillary medical procedure forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom ancillary medical procedure forms that include ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the ancillary medical costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 52.

53. As per claim 54, Freeman in view of Glass and Segal teach the system of claim 53 as described above. Freeman does not explicitly teach identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present ancillary medical procedures put

the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 52.

54. As per claim 55, Freeman in view of Glass and Segal teach the system of claim 54 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present ancillary medical procedures are discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

55. As per claim 56, Freeman in view of Glass and Segal teach the system of claim 54 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

Response to Arguments

56. In the remarks filed 2/95/04 in paper number 20, Applicant argues in substance that (1) neither Freeman, Segal, nor Glass teach management of ancillary medical procedures and costs as discussed in the Interview on 1/27/04; (2) there is not motivation to combine the Segal and Glass references with the Freeman reference.

57. In response to Applicants' argument (1), although the Examiner agrees with Applicants that the management of ancillary medical procedures and costs as discussed in the Interview distinguish over the applied prior art, it is respectfully submitted that the amendments to the claims to further define these terms have not defined the terms as discussed in the Interview.

For example, with respect to claim 1, "ancillary pharmacy costs" are now defined to be limited to "pharmacy costs other than those attributed by a medical procedure performed directly by one of the plurality of physicians." Therefore, the "ancillary pharmacy costs" only exclude costs attributed by a medical procedure performed directly by one of the plurality of physicians. This in no way limits the data gathered from the rest of the plurality of physicians. Accordingly, in the additionally recited steps, the "at least one of the plurality of physicians" can be identified and have their management behavior modified based upon pharmacy costs attributed by a medical procedure performed directly by that physicians.

58. In addition, the additional independent claims similarly define ancillary medical procedures and costs as defined in claim 1, whereby the direct costs and procedures attributable to a physician can be utilized for identifying and modifying. Therefore, the Examiner maintains that the applied prior art teaches the limitations recited in the claims for the same reasons given in previous rejections.

59. In response to Applicants' argument (2), the Examiner respectfully disagrees with Applicants' characterization of the applied references. In particular, all three references are related to enhancing the cost-effectiveness and quality of healthcare services (see, for example, column 4, lines 25-67 of Freeman, paragraphs 1 and 2 of Glass, and paragraph 2 of Segal). Moreover, the Examiner respectfully submits that the motivation to combine these references can be found in the references themselves. For example, it is an explicitly stated function of the "management services" in Freeman determine "more efficient and cost effective ways of doing business." It is asserted by the Examiner that the Glass and Segal references discuss more efficient and cost effective ways of doing business in a health care practice (see paragraph 1 of Glass and paragraph 66 of Segal). Therefore the Examiner maintains that one of ordinary skill

in the art of healthcare management would have been motivated to combine methods discussed in the Segal and Glass references with the system of Freeman.

Conclusion

60. The prior art made of record and not relied upon is considered pertinent to applicant's disclosure.

- Schwartz discusses creating benchmarks for ancillary medical costs within healthcare organizations.
- Shulkin discusses methods for promoting cost-effective physician behavior.
- Pack-Harris teaches a system for analyzing drug costs and utilization rates by individual physicians.
- McCallum teaches a system for compiling and processing physician data.

61. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Luke Gilligan whose telephone number is (703) 308-6104. The examiner can normally be reached on Monday-Friday 8am-5:30pm.

62. If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached on (703) 305-9588. The fax phone number for the organization where this application or proceeding is assigned is 703-872-9306.

63. Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see http://pair-direct.uspto.gov. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free).

CLG
4/30/04